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Investigating the limits of multifunctional agriculture as the dominant frame for Green Care in agriculture in Flanders and the Netherlands

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A B S T R A C T

European agriculture and rural areas are facing multiple socio-economic changes, including a transition from an agriculture-based to a service-based economy. This restructuring forces agricultural and rural actor-networks to reformulate their (self-)definitions. One reformulation prevailing both in policy and scientific circles focuses on the notion of multifunctional agriculture (MFA). This paper critically examines the dominant role that this notion has played in legitimising and shaping the pathways of rural development now present in Europe. More specifically, we examine MFA's role in promoting and organising Green Care as an innovative agricultural activity in the Netherlands and in Flanders (Belgium). We will demonstrate that the MFA frame does not sufficiently grasp the complex reality of Green Care developments. More importantly, the dominance of the MFA frame and related practices and institutional structures enable as well as constrain Green Care's continuity and further development.

1. Introduction

Rural Europe is facing processes of fundamental social change. This 'rural restructuring' (Floysand and Jakobsen, 2007: 208) involves a shift from a rural, agriculture- and manufacturing-based economy towards a more service-centred economy, and a related commoditisation of the countryside as a predominantly residential and recreational area (Woods, 2005). In other words, European countrysides are evolving from being 'landscapes of production' to 'landscapes of consumption' (Cloke, 2006: 19). This evolution is caused and accompanied by manifold socio-cultural processes (Risgaard et al., 2007), such as the increasing mobility and connectivity of goods and services, people and knowledge between different regions, including rural as well as urban areas (Marsden, 2007; Hedberg and do Carmo, 2012); the aging populations and a resulting upward pressure on public spending, particularly for health and welfare provisions (Carone and Costello, 2006); and a trend of healthier living reflected in the 'wellness' phenomenon (Lawrence and Burch, 2010), a positive term associated with vitality, fitness and well-being that relates (amongst others) to the individuals' strong desire to take control of their (future) health.

The interplay of these socio-cultural processes creates a fertile breeding ground for initiatives/activities that combine the common interests of the health and welfare sector as well as the agricultural and food sector in fulfilling the citizens' desire for 'clean and green' foods and services, including stress management and new leisure activities (Lawrence and Burch, 2010). In this connection, an increasingly important activity is Green Care, an umbrella term for a broad spectrum of health-promoting interventions that use biotic and abiotic elements of nature to maintain or promote a person's social, physical, mental, and educational well-being (Haubenhofer et al., 2010). When Green Care occurs in the context of farming activities, we talk about Green Care in Agriculture (GCA), that has been defined as 'the utilisation of agricultural farms – the animals, the plants, the garden, the forest, and the landscape – as a base for promoting human mental and physical health, as well as quality of life, for a variety of client groups' (Memorandum of Understanding of COST866 Green Care in Agriculture, in Dessein and Bock, 2010:11). Starting from this basic definition, research has revealed a wide variety of GCA practices throughout Europe (Dessein, 2008; Di Iacovo and O'Connor, 2009; Sempik et al., 2010). These practices involve different social groups (elderly people, mentally disabled people, former prisoners, youth), various

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farming contexts (intensive and extensive farming, different sectors, professional farms or institutional farms, hospital gardens), and have different objectives (therapy, prevention, health care, rehabilitation). This variety in GCA also becomes evident when considering the different umbrella concepts that are used to describe GCA phenomena (such as Green Care, Social Farming, Care Farming, or Farming for Health), and related types of farms (such as institutional farm, care farm, ordinary farm, *Werkstätte* or social co-operative). More than a mere semantic variation, this glossary of terms designates the representation and organisation of distinct practices.

The development of GCA is one of those processes of rural development that are "essentially about revitalizing and strengthening the rural. […] Rural development aims to reposition the rural within the wider society, by making the rural more attractive, more accessible, more valuable and more useful for society as a whole" (Van der Ploeg and Marsden, 2009: 3). During the past several decades, the several rounds of CAP reforms have gradually broadened rural development policies (Shortall, 2004); from supporting rural development by supporting agriculture-related practices, to giving more attention and financial support to improving the environment and the countryside (pillar 2) and the quality of life in rural areas and encouraging diversification of the rural economy (pillar 3).

In the course of this evolution, Multifunctional Agriculture (MFA) has gained particular prominence as a new agenda for rural development (Niska et al., 2012; Erjavec et al., 2009). MFA refers to the many functions that agriculture does (could and should) fulfil for societies, which go well beyond the cheap production of food and fibre, such as the management and maintenance of natural resources, landscapes and biodiversity (Potter and Tilzey, 2005). It should also contribute to the socio-economic viability of rural areas by creating employment and enhancing the attraction of rural areas for tourists and other users of rural services (Renting et al., 2009). The approaches within the MFA paradigm are diverse (Renting et al., 2009), but they all consider agriculture to be the main driver of rural development, once its multifunctional potential is recognised and put to work. They all share the assumption that farmers are willing to accept multiple responsibilities; that they will reconsider their singular orientation towards primary production and profit maximisation, and instead will diversify the agricultural economy; will build new cross-sectoral alliances; and will adopt more socially responsible modes of production and marketing.

The objective of this paper is to critically examine the role of the MFA agenda in defining and legitimising particular rural development pathways in Europe. For this end, we investigate the case of Green Care in Agriculture (GCA), as GCA is time and again referred to as an element of the 'multifunctional turn' and as typical example of the new activities and services on a growing number of farms that are developing in various ways throughout Europe (eg. Di Iacovo and O'Connor, 2009; Van der Ploeg and Marsden, 2009; Wiskerke, 2009). More specifically, we question the assumption that MFA sufficiently explains the development of GCA throughout Europe. As we will demonstrate, the 'narratives' told about Green Care vary across countries, reflecting different historical pathways, interpretations and practices, as well as different forms of legislative and financial institutionalisation. GCA may, hence, mean different things in different countries, with a variable embeddedness in rural development and MFA. This article explores this variation in frames of meaning and discusses their significance for the future development of GCA.

After a methodological and scene setting section (paragraph 2), we present three different frames used to describe and explain the development of Green Care in Agriculture throughout Europe (paragraph 3). Subsequently, we elaborate upon the cases of GCA in Flanders and the Netherlands, and question the relative position of the three frames presented and their implications for the legislative and financial institutional development of GCA to date (paragraph 4). We then reflect on the consequences that these framings could have on the future development pathways of GCA in particular (paragraph 5), and draw some final conclusions (paragraph 6).

2. Methodology

2.1. Research design

The research starts with an analysis of the different GCA frames throughout Europe. The concept of framing has been introduced in the seminal work of Goffman (1974) and has ever since influenced the analysis of discourses (Scheufele, 1999). Our use of the frame-concept is inspired by the work of Arts and Buizer (2009). Arts and Buizer (2009: 342) describe 'frames of meaning' (which they also call 'discourses as frames') as frames of reference, existing 'in the minds of people, and in the social networks of which they are part. It is based on their experiences and history, of which they may be aware or unaware, but which in either circumstance influences how they speak *and act*' (Arts and Buizer, 2009: 342, our emphasis). Hence, these frames give meaning to social and physical phenomena, and are produced and reproduced through an identifiable set of practices (Hajer, 2006).

Frames are competing interpretations and, as such, like discourses under contestation and unstable (Arts and Buizer, 2009). Unravelling their difference and predominance unveils the political nature of the social construction and transformation of social phenomena (Fairclough, 2005). Our aim is similar: by unravelling the occurrence of different and competing interpretations of GCA, we want to contest the seemingly univocal interpretation of GCA within multi-functionality, and discuss the possibility of different development pathways. In analysing the occurrence of different GCA frames we study narratives and their interaction with actions and (institutional) practices (Arts and Buizer, 2009). We are inspired by Bevir's (2006) interpretative analysis of narratives that explains practices and actions through their reflexive interaction with actors' interpretations of the world.

Based on data and insights from groups of experts and practitioners, gathered during the year-long involvement of the authors in international networks dealing with GCA -both academic networks such as 'COST866-Green Care in Agriculture' (Dessein and Bock, 2010; Sempik et al., 2010) and the FP6-funded project 'Social Services in Multifunctional Farms' (Di Iacovo and O'Connor, 2009), and the more practice oriented 'Community of Practice Farming for Health' (Hassink and van Dijk, 2006; Dessein 2008), three frames were outlined. These were triangulated, adapted and refined during three consecutive rounds of feed-back and discussion with international experts (in Modena and Antalya in 2009 and in Witzenhausen in 2010).

To understand how these frames are constituted in and are constitutive of practices of GCA with a focus on institutionalisation and financial structuring, we used an explanatory, multiple-case (holistic) research design (Yin, 2009). We made use of multiple sources of evidence such as observations in project meetings of the aforementioned international networks, regional and national umbrella organisations and non-profit organisations operating in Green Care; field visits; regular updates from key persons; scientific literature; legislative texts; policy documents and grey literature that were considered as key documents in the history of social farming. The data were collected in the period 2009–2011. These sources of evidence were complemented in Flanders with a series of 21 semi-structured qualitative interviews with actors involved in

social farming operating in different sectors (agriculture, health care, education), and at different institutional levels (government, umbrella organisations, farmers, health care facilities, (parents of) clients and non-profit organisation). The interviews dealt with the history of the individual or his organisation regarding GCA, with the interviewee's evaluation of current GCA institutions and practices and with his future perspective on these institutions and practices (De Krom and Dessein, 2012). The Dutch case was complemented with the results of a recent project on multifunctional agriculture (Oostindie et al., 2011a,b) and the first insights based on a case study on 'Learning & Innovation Networks for Sustainable Agriculture' (LINSA) on green care in the EU FP7 funded project SOLINSA (www.solinsa.net; Roep, oral communication 2012).

2.2. Setting the scene of the case studies

The unit of analysis of the two selected case studies, is defined by the policy level that governs the institutionalisation and financial structuring of GCA. In the case of Belgium, the unit of analysis is Flanders (NUTS1), the Northern region of the country, as the Flemish government is responsible for policy domains as agriculture, rural development, health and welfare. The second case study is the Netherlands as a whole, given the national level for decision making for the respective policy domains. Flanders and the Netherlands are both urbanised areas with a high population density, and a countryside that is challenged by processes of urbanisation and claims of new consumers of the countryside, such as tourism, nature conservation, services and new dwellers. In this context, agriculture is on a double track, with on the one hand processes of further intensification and specialisation, and on the other hand diversification and broadening. Rural development is gaining more attention in both case study areas.

In Flanders and in the Netherlands, GCA practices take place almost exclusively on family-owned farms. Farms offering GCA services can be specialised or mixed, but have in common that they (are supposed to) derive their main income from primary production (dairy, crops, horticulture, cattle, poultry). Great importance is attached to the immersion of the clients in 'ordinary' farm contexts, the involvement in 'normal' and hence relevant and useful physical work, and the social interaction with 'normal' farmers and their families, or within family-resembling groups of clients and farmers. In other words, GCA offers an informal, familial context that is considered to be close to 'normal' life (Hassink et al., 2010; Dessein et al., 2009). Clients come to the farm for a number of days, either consecutively or non-consecutively, usually without lodging on the farm. They are mainly engaged in regular farm activities.

In both countries the number of care farms and clients has dramatically increased in recent years. In the Netherlands, according to the CBS, the statistical bureau of the Netherlands, the number of care farms increased from 474 in 1999 (0.5% of all farms) to 1211 (1.7% of all farms) in 2011 (http://statline.cbs.nl/statweb/ accessed 22.2.2012). The figures of the Federation of Agriculture and Care (Federatie Landbouw en Zorg, www.landbouwzorg.nl) are less up-to-date but give a more complete picture as they include not only registered agricultural businesses (as CBS does) but all care-farms. Among them are also care-farms that are part of health care institutions as well as an increasing number of care farms started by former employees of care institution (Hassink et al., 2007b). The Federation of Agriculture and Care lists 214 care-farms in 2000 and 1088 in 2009 (www.landbouwzorg.nl, accessed on February 22, 2012). The variety in Dutch care farms is great: they differ in size, approach, services offered as well as target groups. In 2009 care-farms offered services to elderly (24% in 2009) but also young clients (32%), clients with mental problems (39%), and intellectual disabilities (3%).

In Flanders, the number of subsidised care farms increased from 147 (or 0.4% of the farms in Flanders) in 2006 (when the Flemish government started to subsidise care farms, see below) to 557 in 2011 (or 2.88% of the farms in Flanders). In the same period, the number of unsubsidised farms increased from 65 to 1300. The number of care days in the same years in Flanders increased from 8223 to 32,300 (Steunpunt Groene Zorg, 2012). More than 60% of the clients are youngsters from youth welfare work; more than 30% are clients with a mental or physical disability. Although no exact figures are available, experts consider the variety in size, approach, services offered as well as target groups as less diverse than in the Netherlands.

3. Green Care and its multiple frames of meaning

Relying on scientific literature, as well as on discussions with experts and practitioners (see methodology section), three main frames come to the fore when comparing different GCA representations, organisational styles, and practices throughout Europe: 1) the frame of multifunctional agriculture, 2) the frame of public health and 3) the frame of social inclusion (based on Bock and Oosting, 2010).

The *frame of Multifunctional Agriculture* considers Green Care activities to be one of many on-farm activities that stimulate the economic or social sustainability of agriculture. Economic studies have aimed to demonstrate that Green Care constitutes one of the most important sources of income for multifunctional farmers and hence contributes to the economic viability of multifunctional farms (Hassink et al., 2007b; Oltmer and Venema, 2008; Van der Ploeg and Roep, 2003). From a social sustainability perspective, Green Care is presented as one of the multiple new functions that agriculture can fulfil in an urbanising society (Wiskerke, 2009), which contributes to the social acceptance of farming and farmers' societal 'licence to produce' (Meerburg et al., 2009). Within this MFA frame, Green Care is typically represented as 'care farming', which highlights the importance of the care provision within the farm sector and outside of professional health care institutions. Entering the normal daily world of an 'ordinary', professional farm business; participating in 'normal' daily farm work; and interacting with a 'normal' farm family and sharing life together with the family, is presented as an integral part of the healthy and curative farm environment (Elings and Hassink, 2008).

Farmers should know how to deal with their clients, but avoid becoming health professionals; they should therefore refrain from engaging in explicit therapeutic interaction. They should remain 'themselves, 'real' farmers (Enders-Slegers 2008). In their study of autistic children's visits to a care farm, Ferwerda-Van Ferwerda-van Zonneveld et al. (2008) described the importance of the farmer as a role model and attachment figure. They concluded that farmers are important as a personal intermediary between care institutions and parents, and important for monitoring and evaluating the behaviour and performance of clients in a non-institutional setting. Care farmers aim to provide 'care' in a new way, on a small scale, which allows for personal attention and individual care. This sets it apart from institutional and other forms of health care.

These activities can be paid for from several sources, such as subsidies from the Ministry of Agricultre (as in Flanders, see below), from the added value for products that are produced in an ethical way (Carbone and Senni, 2010), or from direct payments from clients or health institutes (as in the Netherlands, see below). Alternatively, the services are not remunerated at all, which places the emphasis exclusively on social sustainability.

The *frame of Public Health* underlines the therapeutic effects of interacting with, and being active in, nature. Within this frame,

Green Care primarily provides health restoration and protection, disease prevention, and health promotion (Hine et al., 2008). Farmers may offer the green environment (their farm) but are not perceived as important actors in the therapeutic process. Predominantly, Green Care activities do not take place in 'normal' professional farms but in institutional, therapeutic farms or gardens, and are always under the supervision of a specialised therapist. Green Care practices tend to be integrated within holistic health care approaches, which attach importance to embedding health in specific physical and/or socio-cultural contexts. These holistic approaches emphasise the restorative effects of being in and dealing with natural environments (De Bruin et al., 2010; Verheij et al., 2008), such as mental and emotional benefits from caring for animals (Ferwerda- van Zonneveld et al., 2008; Berget and Braastad, 2008) or plants (Ziwich et al., 2008). Some approaches underline the beneficial effects of 'healthy' landscapes (Van Elsen and Schuler, 2008) and the importance of the (physical and spiritual) experience of the growth and change inherent to natural cycles and seasons (De Vries, 2006). Losing contact with the 'earthly' basis of human existence may also be seen as a cause of illness; re-establishing contact with nature may accordingly restore physical and mental well-being.

The Public Health frame can be situated in a wider discussion in the health care sector about the dominance of the biomedical model, and the negative effects of medicalisation and institutionalisation of care. Within this discussion, pleas are made for more community-based care and the social reintegration of patients (Bachrach, 1996; Bauduin et al., 2002), which is often linked to the concepts of participation and empowerment of patients and the ethics of care (Barnes, 2008). Along with other forms of 'alternative' treatments, scientific and public interest in the restorative effect of a green and natural environment is growing (e.g. Sempik et al., 2010).

These Green Care activities are paid for from institutional budgets, just like any other therapeutic activity. They may be financed by the Ministries of Health, health insurances, private health associations, or directly by clients. Professionals involved in Green Care arrangements are formally employed and paid through their regular wages. Some of them may work as independent professionals at official fee rates. Institutional farms are part of the health care institution and financed through regular budgets. In cases of farmer involvement, the farmer tends to be formally employed by the institution and is paid according to an official wage scale. The primary farm products may be sold or used in the institution. In both cases, the 'profit' (in cash or kind) remains property of the institution and not the farmer, even when reinvested into the farm.

The *frame of Social Inclusion*, finally, focuses on re-integrating socially excluded persons in society by providing on-farm labour. Socially excluded persons do not 'participate in key activities of the society in which he or she lives' (Burchardt et al., 2002: 30) or are 'unable to participate in the normal relationships and activities available to the majority of people in a society, whether in economic, social, cultural or political arenas' (Social Exclusion Unit, 2004) – such as long-time unemployed persons, former drug addicts and ex-prisoners. The goal of their engagement in farm labour is to re-establish the habit of working, and to increase their knowledge skills and self-esteem. These aspects should eventually enable them to find employment in the regular labour market and to re-integrate into society. Part of this Green Care philosophy is also the belief that manual physical labour generates well-being and a capacity for work (Hine et al., 2008). Agriculture offers a type of manual, unskilled labour which is running low in the labour market. The immersion in 'normal' work with structured working hours and the interaction with 'normal' people are considered to be important benefits of Green Care activities. From the perspective of care providers, social justice and an ethic of care are important elements of the philosophy. Care providers feel a sense of responsibility, and are motivated to make modern society more inclusive by offering a home and sense of belonging to those living on the margins of society (Di Iacovo, 2008).

The organisation and payment of such activities takes many forms. Green Care may be organised by formally recognised organisations, such as rehabilitation centres, prisons, or social services. In this case, public social service budgets pay for the activities in question. The clients may also receive compensation for their labour as part of the reintegration process. This is the case in institutional farms that belong to a prison or are set up for the purpose of social integration. When inmates work for 'ordinary' farmers, the farmers may also pay them for their labour. Farmers can receive payments from social services as an encouragement (or compensation) for employing 'difficult' labourers. The commoditisation of 'care' in the sale of ethical products may also provide the farmer an extra income (Carbone and Senni, 2010). In many cases, however, this kind of Green Care is voluntary and considered part of the civic engagement of individuals, groups or social movements; there are no formal payment structures and monetary costs and benefits are considered unimportant (Di Iacovo, 2008).

The above classification of frames is ideal-typical. In practice, Green Care activities share characteristics of several of these frames. However, the wide variety of Green Care practices throughout Europe can be linked to the dominant position of one of the three frames in specific countries, which leads to a tendency to organise and govern GCA in a particular way. For example, Green Care is viewed within the frame of public health in Germany (Neuberger et al., 2006), Austria (Wiesinger et al., 2006), and the UK (Hine et al., 2008). The frame of social inclusion predominantly informs the organisation of Green Care practices in Ireland (Di Iacovo and O'Connor, 2009), and Italy, where GCA is mostly organised by cooperatives as part of their voluntary civic and political engagement (Di Iacovo, 2008; Di Iacovo and O'Connor, 2009). Apart from Belgium and the Netherlands (see below), the frame of Multifunctional Agriculture seems to dominate the organisation of Green Care activities in Norway (Vik and Farstad, 2009) and, to a lesser extent, Slovenia (Di Iacovo and O'Connor, 2009).

4. Case studies: legislative and financial institutionalisation of GCA in Flanders and the Netherlands

In Flanders and in the Netherlands, GCA is appraised and promoted in a rather similar way. The on-farm organisation of GCA practices also share many similarities. In both regions GCA can be considered as typical representatives of the MFA frame, as we will elaborate below. But Flanders and the Netherlands diverge greatly in terms of the institutionalisation, and especially the financial structuring, of GCA. In the Netherlands, GCA has become financially integrated into both the agricultural and the public health care systems while Flanders has institutionalised GCA as a voluntary – and hence not formally paid – agricultural service.

4.1. Institutionalising Green Care: different legislative and financing structures

Although Green Care practices have a century long, informal history (Roosens and Van de Walle, 2007), the legislative and financial institutionalisation of Green Care practices is a recent phenomenon. Nowadays, both Dutch and Flemish farmers receive a financial incentive to deliver health care. Despite the organisational similarities underlying on-farm GCA practices in both countries,

this incentive varies considerably in size. Moreover, the accompanying financial arrangements, legislation, and policies differ substantially.

In October 2005, the Flemish government regulated social farming through the application of the First Flemish Rural Development Programme (Ministry of the Flemish Community, 2005). Since December of the same year, professional farmers can apply for a social farming subsidy from the Ministry of Agriculture. Nowadays, these subsidies are paid by the Ministry of Agriculture of the Flemish Government. For a short time (until 2007), the European Commission allowed this subsidy to be taken from Axis 3 of the Flemish Rural Development Programme, but this Support Scheme was not longer accepted in the 2007–2013 Programme. Since 2007, permanent support schemes are only possible under Axis 2 (which currently leaves no opening for GCA), while Axis 3 is dedicated to non-structural support of activities needing a financial kick-start (O'Connor et al., 2010).

The Flemish governmental subsidy is 40€ per day, independent of the number of clients, with a maximum of three clients. To be eligible for the subsidy, applicants must comply with the legal definition of the profession 'farmer'.[1] Moreover, applicants are obliged to collaborate with a care facility that is recognised by the Health Care Ministry or with a counselling centre for school students belonging to the Ministry of Education. These organisations may not pay a salary to farmers, only an expense allowance. Applicants are also obliged to use an official care farm contract that specifies the responsibilities of the farmer, the care institution, and the client. The Agricultural Ministry is responsible for monitoring whether farmers are eligible to receive the subsidy; care facilities are responsible for assuring the quality of social farming practices, and are in turn monitored by the Health Care Ministry. The farm itself is not recognised as a care institution (De Krom and Dessein, 2012).

Flemish Green Care activities are supported by an umbrella organisation (Green Care Support Centre or 'Steunpunt Groene Zorg'). The Support Centre functions as both a middleman and farmers' advocate. It searches for and screens interested farmers and suggests to the facilities which farms or farmers may fit their clients' wishes and needs. The Support Centre also aims to assist and protect farmers. In this way, the Support Centre helps to assure that only the clients with manageable care needs actually enter the social farms. The Support Centre aims to protect farmers from misuse by the institutions, and serves as a body to which farmers can communicate complaints. The Support Centre either addresses the complaints itself or communicates them to the appropriate organisations or government agents. The Support Center also provides the farmer withguidelines for high-quality cooperation between farmers, clients and health workers. The Support Centre is now seeking financial support and recognition by public health agents for its work by seeking structural funding from the Flemish Ministry for Health Care (Steunpunt Groene Zorg, 2011). To date, this ministry does not provide any funding to the Support Centre. The Support Centre was initially co-financed by the Agricultural Ministry with funding from European Rural Development, but starting in 2007 the EU stopped such funding, in part because the EU considered social farming to be a health care practice, and health care is not the task of the EU (Flemish Parliament, 2010). From late 2008 till late 2010, the Agricultural Ministry co-financed the Support Centre to support agricultural diversification within the framework of the EU sugar restructuring scheme. Since late 2010, the Centre no longer receives funding from the Flemish government and now operates on non-structural provincial funds and private money from the Flemish Farmers' Union.

In the Netherlands, Green Care gained popularity during the 1990s as part of a diversification strategy and the adoption of new on-farm activities as additional sources of income (Van der Ploeg and Roep, 2003). In most cases, farm women initiated such activities to create their own employment, because many of them had experience working in the health care sector (Bock, 2004). The Ministry of Agriculture, Nature and Food Quality stimulated Green Care as a new on-farm activity and additional source of income, in collaboration with the Ministry of Health, Welfare and Sports. These two ministries subsidised the foundation of a National Support Centre for Agriculture and Care in 1999 (Elings and Hassink, 2008). During that period of time, care farms have not only grown in number but also in professionalism and institutionalisation, resulting among other in the development of certification systems and education programmes. When the subsidy stopped in 2008, the support centre was closed. But shortly after, in 2009, a new national organisation was established – the Federation for Agriculture and Care ('Federatie Landbouw en Zorg', Elings, 2011). The Federation represents the interests of the care farms at the national level and negotiates with the relevant organisations (ministries, health care institutes, insurance organisations) (www.landbouwzorg.nl).

In addition, regional care-farm associations support individual care farmers by offering services such as quality assessment and quality assurance (including certification), legislative lobbying and advocacy, and matching care-seekers with farmers. They also organise training activities for care farmers, sometimes in the form of certified and officially recognised modules of secondary professional education.

One of the major problems of Dutch care farmers was how to organise the funding of their care activities. Since 1995 the AWBZ, the collective health insurance costs for long-term care, had been the major source of funding, accessible either in collaboration with institutions with an AWBZ accreditation,[2] or through direct payment by clients with a so-called Personal Health Care Budget (PGB). The latter has greatly increased since PGB's became accessible for a much broader range of clients in 2003 (Di Iacovo and O'Connor, 2009).[3] According to the Federation for Agriculture and Care, care farmers organised their finances in 2009 as follows: 24% were directly paid by health insurance (58% in 2004) and 42% were paid through Personal Health Care Budgets (34% in 2004).[4] In addition, 33% used other funds, e.g. for social (re)integration (3% in 2004) or

[1] The profession of 'farmer' has been defined within Flemish legislation as "a person running an agricultural company with a minimum labor requirement of 0.5 full time employment, and who spends a minimum of 50% of his working time at the agricultural company and earns at least 35% of his employment income from agricultural activity".

[2] Only accredited institutions may offer activities to be paid for by the AWBZ through the Exceptional Medical Expenses Act. Clients need to prove that they are in need of AWBZ-funded care; once they have achieved this status, they can choose between using the services of an AWBZ-accredited organisation or paying for services of their own choice, outside of formal health care institutions, by way of a Personal Health Budget (PGB). Since 2003, care farms may be accredited for AWBZ funding; but also regional federations have successfully applied for accreditation and organise the AWBZ funding for their members through this collective accreditation (http://www.landbouwzorg.nl/index.php?pagid=62, accessed 22.2.2012).

[3] Recently the AWBZ (Exceptional Medical Expenses Act) has been drastically reorganised and with it the eligibility for PGB's has been substantially reduced. AWBZ is now only available for clients with very serious health problems and medically necessary care activities. Part of the budget has been transferred to the WMO ("Law for Social Support"), giving the municipalities the responsibility for the AWBZ target group with less serious health problems.

[4] The total includes 47 institutional farms in 2009 and 86 institutional farms in 2004 (www.landbouwzorg.nl accessed 22.2.2012).

were not paid at all (0.5%; was 6% in 2004). In general, payment primarily originated from regular public health budgets, although other funds are being increasingly used. Payment by way of regular health care budgets increased the pressure for quality assurance, which led care farmers to organise themselves via regional associations and the national umbrella organisation as mentioned above. In addition to the direct payment for care activities, some farmers present their social engagement as an added (ethical) value to their agricultural products. In this way, they can justify and receive a higher price, which increases the profitability of providing Green Care. As a result, Green Care has become a significant source of income: in 2009 the total turnover was 50 million euro (Roest, 2009); in 2011, a turnover of 69 million is expected (Elings, 2011). Recent research into multifunctional agriculture revealed that farmers estimate a turnover of 100 000 euro in 2009 from Green Care activities alone (Oostindie et al., 2011b). Most care farmers offer other (multifunctional) services too, such as direct sales, education or child care; all together, these activities contributed to an average turnover of 130 000 euro in 2009. For farms engaging in these activities for less than 10 years the average was 95 000 euros, while for those active for more than 10 years, the turnover averaged 240 000 (idem, page 38). In many cases, the continuation of the farms is assured through the income generated through care activities.[5] However, with the recent cuts in and the reorganisation of the public health budget (see footnote 3) as well as social budgets, the future may be more uncertain (Oostindie et al., 2011a; Hassink, 2012). This is difficult to forecast, but it is possible that the crisis in the public sector, with on-going cuts in public health budgets, may support the collaboration between health care institutions and care farmers, as their services are often cheaper than services provided in institutions. In the mean time care farmers and their associations are actively searching for new services and new target groups, such as special education and social rehabilitation and reintegration, and return-to-work projects (Hilhorst et al., 2011; Koulil, 2009). In this connection they seek the collaboration with the municipalities that recently became responsible for organising and managing the social rehabilitation and reintegration of a considerable group of former AWBZ target groups (Oostindie et al., 2011a; Koulil, 2009).

4.2. The influence of frames on Green Care practices and their institutionalisation

In Flanders and in the Netherlands, GCA is initially discussed using the 'MFA vocabulary', which focuses on the care provision and healthy environment being a service provided by farmers who are innately driven to share their healthy lifestyle and surroundings with other members of society. This frame reflects an origin of voluntary care provision by farmers and their families. However, elements of the public health frame underlie both the Dutch and Flemish GCA arrangements, where discursive emphasis is placed on the positive effects of care delivered outside of large, impersonal medical institutions. In GCA, the focus is on the needs of individual patients and his/her abilities rather than the illness. Other elements of the public health and social inclusion frames are reflected in the importance attached to regenerative effects of the clients' integration into the farmers' community and family.

Despite the discursive similarities between the two countries, the institutional embeddedness of GCA differs greatly between the Netherlands and Flanders. In the Netherlands, farms are eligible for payment via health care funds. In Flanders, farmers are compensated for the loss of regular (agricultural) income as a result of their voluntary social engagement; they therefore receive a compensating subsidy from the Ministry of Agriculture. This difference not only concerns the legal position of Green Care farms and the economic significance of GCA for Dutch and Flemish farmers. It also implies fundamental differences in how the social function of agriculture, as promoted in the MFA agenda, may be understood and implemented.

We have demonstrated (De Krom and Dessein, 2012) that the financial involvement of the Flemish agricultural sector, and the absence of Flemish health care funds for supporting GCA, can be understood through analysis of the frames of meaning underlying the process of institutionalising GCA.

In the 1990s, Belgian agriculture was seen as a 'sickener' because its main objective appeared to be profit maximisation and farmers paid too little attention the negative environmental impact of agriculture. In addition, international food crises abounded and in 1999, the Belgian population was alarmed to learn that toxic dioxins had entered the food chain. The Ministry of Agriculture and the farmers' unions then started to look for ways to change the image of 'sickener' into an image of 'healer' or 'carer'. Social farming seemed to be a good way to enhance the social position and (self-) image of farmers.

Three main aspects of the frame of multifunctional agriculture are clearly present. First, the farm is conceptualised as an environment that follows the cyclical rhythm of nature.[6] Second, the farmers (and their families) are seen as intrinsically good carers, because they are down-to-earth, straightforward, their days are well-structured and many of their activities relate to providing care to animals and plants, which is considered as being closely connected to caring for human beings. Finally, the frame points to the historical presence of providing care on farms, using this as evidence that social farming comes more or less naturally to farmers' families.

The coalition of the Ministry of Agriculture and farmers' representatives wanted to avoid the perception of GCA as being just another way of making money. GCA was presented as a contribution to social sustainability, not to the economic performance of an agricultural enterprise. In a context of agricultural intensification, specialisation and mechanisation, it is difficult to accommodate this type of care activities (Flemish Parliament, 2002a). Therefore, a compensating subsidy was considered as being justified, together with legislation outlining the responsibilities of farmers and care facilities to assure high-quality care on farms, as well as guidelines regarding insurance. The regulations prevent the clients from being misused as cheap labourers and guarantee that they receive care on the farm. The subsidy is not a payment for supplying care, but is a compensation for loss of agricultural production time. This loss is considered to be equal, regardless of the number of clients visiting a farm.

In 2000, the Flemish Ministry of Health Care acknowledged the importance of re-integrating patients into society by providing them with unpaid work outside of care facilities, in a well-structured context that has social contacts, personal development, and social respect (Flemish Parliament, 2000). This is made possible in a wide spectrum of green, community-based, and informal care arrangements, including, but not limited to, Green Care (Flemish Parliament, 2002b). There are several environments where clients could work in a non-therapeutic (i.e. non-institutional), yet structured environment, receive personal attention by non-professional

[5] For multifunctional activities as such the contribution to the overall income is estimated as 40% (Oostindie et al., 2011a,b).

[6] The Flemish Parliament (2001: 12) describes a farm in this context as "an environment with the rhythm of the seasons, the growth of plants and animals and furthermore […] the serenity of nature", making it a location "par excellence to offer good possibilities to recover for persons with care needs".

carers, and be placed and activated according to their specific care needs. Farms are just one of them (Dedry, 2004).

The coalition of health care sector representatives and the Health Care Ministry represented social farming as 'care through socialisation'. This placed GCA into the Public Health frame, but it was not considered to be a distinct, professional care arrangement. Therefore, GCA did not require specific health care legislation. The quality of GCA activities, just as any other extramural care activity, must be ensured according to existing legislation and the care facilities themselves have to decide whether GCA is a suitable activity for their clients. From this perspective, a subsidy scheme or any other form of payment is problematic, as it might motivate the farmers to start social farming for economic instead of social reasons.

In the Netherlands, GCA has a strong discursive basis in the MFA frame in a similar way as in Flanders by referring to the healthy natural rhythm of agriculture, the healthy down-to-earth 'normality' of farmer families and the intrinsic moral motivation of farmers to supply social and care services (Hassink et al., 2007b; Hopkins, 2011). At the same time the MFA premise that GCA should create a substantial additional income comes clearly to the fore. In the Netherlands the purpose of GCA is not only to create goodwill in society and continue agriculture's licence to produce, but also to develop a new profitable on-farm activity (Hassink et al., 2007a).

This is also reflected in the Dutch coalition of actors supporting the MFA agenda, in which the Ministry of Agriculture and the farm unions play an important role in promoting GCA as one of the services a multifunctional agriculture has to offer and one of the flagships promoting the image of agriculture as such. Differently than in Flanders, however, this does not preclude the notion of payments and profitability. In the Netherlands GCA are represented as an example of innovative rural entrepreneurship which is also part of the MFA frame (Niska et al., 2012). Being paid for care services, underlines the professional quality of the care providers and their services and is rather supporting their acceptability than undermining it. At the same time, farmers and their associations stress that the moral desire to help vulnerable people and to share the healthy rural life with them is an important driver and part and parcel of their personal satisfaction as a care farmer (Oostindie et al., 2011b).

The Ministry of Agriculture played a crucial role also in constructing the (material and discursive) bridge that linked agriculture to public health. This took place through its initial collaboration with the Ministry of Health and support for the organisation of care farmers and their negotiations with health care institutions. These negotiations included discussions about the possibilities of agriculture to contribute to health, the eligibility of certain client groups and the potential role of farmers in health care in offering care activities without the normally required training. Through these discussions a new frame of care farming was constructed, which stressed the healthiness of care outside institutions and provided by non-experts in a healthy green environment. But their negotiations also regarded the materiality of green care and eventually opened the path towards payments of care farming through health care budgets.

At the same time the income-creating basis of GCA invited Dutch farmers to invest in health care oriented professional training, either because such training helped them to provide care more competently and raised their competitiveness on the market for GCA, or because health care institutions demanded extra training. Payment from the health care budget brought the requirement of quality assurances, including certification of professional knowledge and experience and substantial investments to ensure the safety of the clients on GCA farms. At this point, one may argue that the borders between GCA and public health care start to blur. Health care innovation was and is an important driver behind the development of on-farm health care activities. The increasing number of health care professionals starting Green Care enterprises, with farming as a side activity to care provision instead of the other way around, may be interpreted as a success of care innovation and de-institutionalisation, but may also be interpreted as a 're-medicalization' of Green Care. It anyhow confirms the trend towards professionalisation and institutionalisation of GCA in the Netherlands. In its course the Public Health Care frame of GCA comes more to the fore and challenges the traditional dominance of the MFA frame as a representational and organisational source underlying Green Care arrangements in the Netherlands.

5. Discussion

In this paper, we have discussed how different GCA frames relate to the legislative and financial institutionalisation of GCA in Flanders and the Netherlands. In the Netherlands, the initially dominant MFA frame has become punctuated by elements of the public health frame, resulting in an increasing marketisation and a concomitant need to professionalise, collaborate with public health institutions, and adopt public health norms and values as well as procedures. In Flanders, GCA has remained firmly embedded in the agricultural domain that subscribes to the MFA frame and considers Green Care a social service and not an economic activity. This underscores its informal, non-professional character, and has prevented its recognition as an activity requiring financial support from public health funds. The relative position of frames may be dynamic and changing over time. Yet, we should not overlook that possible path dependencies of GCA frames, institutionalisations, and the dialectical relation between both, might cause lock-in situations (Stassart and Jamar, 2008) and prevent further shifts in the relative position of these frames and related practices.

In the Netherlands, the interpenetration of the MFA frame by the Public Health frame led to the liberalization of the Green Care sector, and the introduction of the Personal Health Care Budget. This evolution is likely to instigate further professionalization and institutionalisation of GCA, with accompanying pressure towards specialisation and scale enlargement. As a result, care farming may become a profession in itself, with more precise regulations and requirements regarding the training of Green Care providers and facilities. Such a development would limit the possibilities of 'ordinary' farmers to develop care as one of multiple strategies within their multifunctional strategy, as they would be unable to compete with 'professional' care farms. Accordingly, much of the original attractiveness of GCA for clients of the service, which is based on its informal, non-institutionalised character, might be lost. What is more, the success of linking GCA with the public health sector and the health care budget – which initially stimulated the growth of GCA in the Netherlands – may contribute to GCA's demise because of the current economic crisis and budget cuts. With the recently announced substantial cuts in the public health care budget (3.9 billion euros in 2011–2015),[7] including a rigorous reduction in the Personal Health Care Budget and direct AWBZ payments, the future of the Dutch model of GCA is uncertain. Accordingly, we may question the crisis resistance of the Dutch GCA model because of its public health orientation.

The GCA practices in Flanders are probably more resilient to deal with the above-mentioned socio-economic trends. Flemish Green Care farmers have remained 'ordinary' farmers because the practice

[7] New, additional budget cuts were being discussed while this paper was being prepared. (http://www.rijksoverheid.nl/onderwerpen/overheidsfinancien/begrotingsbeleid-2011-2015, accessed on 22 Feb. 2012).

of GCA has not been embedded in a socio-economic and policy environment that stimulates a professionalisation and commercialisation of the practice, which would require and invite capital intensive investments, scale enlargements, and care specialisation. These GCA farmers develop their farming business in a multifunctional way, and engage in care activities because of social rather than economic reasons. This stronger resilience, however, is mainly based on its historical ineffectiveness to establish innovative, cross-sectoral collaboration. This situation also makes the Flemish practice of GCA completely dependent on the endurance of the interest of the agricultural sector. If the agricultural coalition no longer needs Green Care to gain public sympathy for their licence to produce, or if this activity is replaced by a new one which can serve the same purpose in a more efficient and effective way, the agricultural coalition might lose interest in Green Care activities. The Green Care Support Centre, with its singular reliance on funding from the agricultural coalition, plays a crucial role, together with the motivating effect of the subsidies for the farmers. If this support would fall away, Green Care in Flanders would most likely wither away. Given the non-commercial character of GCA in Flanders, this might have only limited impact on the economic performance of the farm business as such. However, the risk entailed in the non-payment for activities and services which are of great value to the clients, makes these clients very vulnerable.

6. Conclusion

Haubenhofer et al. (2010) have shown that the variety of existing Green Care practices largely exceeds the practice of Green Care in Agriculture (GCA), and includes practices as varied as 'healing gardens', 'green exercise', 'horticultural therapy', and 'animal-based health care interventions'. To develop a broad spectrum of green care activities, including GCA, they advocate establishing innovative, cross-sectoral linkages through the interaction, communication, and flow of information between actors (individuals, offices, or organisations) that were not linked before. In Flanders and in the Netherlands, the initial delimitation of GC within the agricultural sector, and the dynamic relations between the frames of Public Health and MFA that grew from this initial delimitation, have shown the opportunities, limits and challenges of such innovative, cross-sectoral Green Care institutions and practices.

A strong MFA focus on existing farms dampens incentives to develop other agriculture-related Green Care arrangements, such as for example institutional care farms or urban care farms. In institutional care farms, agriculture supplements other practices (human health, social inclusion-based practices) but is not at the heart of the GCA practice. Agriculture is not (necessarily) a profit oriented business, but can be a mere means to help clients. Regardless of their institutional context, such arrangements still allow clients to experience an agricultural lifestyle and the restorative effects of being in nature. Furthermore, they support the development of new relations between agriculture and society at large, as we can learn from experiences in Italy (e.g. social cooperatives), Greece (e.g. prison farms) or Germany (e.g. "*Werkstäte*"). All of these are inspired by the Public Health and Social Inclusion frames (Di Iacovo and O'Connor, 2009).

Especially in Flanders, the MFA frame inhibits the development of (peri-)urban care farms, and thereby constrains the (re-)building of urban–rural relations which could help agriculture and rural areas to cope with the challenges they face. The formal demands (such as being a recognised farmer) as well as the non-commercial character of the Green Care activities make it difficult for farmers to establish a Green Care farm within or nearby a city. In the Netherlands, the preconditions for developing urban Green Care activities are much more favourable, given the potential for profitability and the fact that being registered as a farmer is not a formal requirement.

The cross-sectoral linkages have been established more successfully in the Netherlands than in Flanders. However, the very success of combining the representative and organisational principles of both the MFA and Public Health frames currently threatens the sustainability of Dutch on-farm Green Care practices. In Flanders, the continuing dominance of the MFA frame in informing GCA arrangements saves Flemish care farmers from the immediate threats posed by current economic crisis-based cuts, but comes at the cost of a lack of cross-sectoral, innovative cooperation.

This paper has shown that the use of only the MFA discursive positions to assess GCA, its future development and its contribution to rural development, does not grasp the complexity of the GCA dynamics in Flanders and the Netherlands. It also shows that innovative, cross-sectoral linkages are hard to establish. Therefore, future research on the development of GCA in other European countries, with a focus on the frame (s) that framed the initial GCA activities, on the development pathways, and on the capacity to innovate in a cross-sectoral way, will be useful to better understand GCA and its potential to further develop. Several questions then arise: Which discursive model will most effectively give rise to a new system of interdisciplinary innovation in GCA? Will it be the MFA-based models used in the Netherlands and Flanders, which are at least as constraining as enabling? Or will it be the Public Health- or Social Inclusion-based models as found in other European countries? Only the future holds the answers.

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